PURPOSE OF TRAINING

• TO ENSURE THAT DOCUMENTATION IS IN COMPLIANCE WITH STATE AND FEDERAL CONTRACT AND REGULATIONS

• TO ENSURE ALL PROVIDERS UNDERSTAND & APPLY DOCUMENTATION REQUIREMENTS

• TO PROVIDE ALL STAFF WITH SAME FOUNDATION AND GUIDANCE

• BHRS DOCUMENTATION MANUAL- CAN BE FOUND AT: HTTPS://WWW.MARINHHS.ORG
IMPORTANT CONNECTIONS: ASSESSMENT, CLIENT PLAN, & PROGRESS NOTES

- Assessment is critical for establishing the basis forMedical Necessity—diagnosis and functional impairment.

- Client Plan
  - INFORMED BY THE ASSESSMENT
  - LINKS THE FUNCTIONAL IMPAIRMENTS TO THE INTERVENTIONS
  - AUTHORIZES THE INTERVENTIONS PROVIDED DURING A SERVICE ONCE SIGNED BY SUPERVISOR

- Ongoing Care Note:
  - DOCUMENTS MENTAL HEALTH INTERVENTION(S) ADDRESSING CONDITION, I.E. DIMINISHING IMPAIRMENT OR PREVENTING DETERIORATION
  - MEDICAL NECESSITY MUST BE CLEARLY DOCUMENTED IN EACH ONGOING CARE NOTE
• WHAT IS THE GOLDEN THREAD?

• THE GOLDEN THREAD IS THE CONSISTENT PRESENTATION OF RELEVANT CLINICAL INFORMATION THROUGHOUT ALL DOCUMENTATION FOR A CLIENT. THE GOLDEN THREAD BEGINS WITH AN INTAKE ASSESSMENT THAT CLEARLY IDENTIFIES AN APPROPRIATE CLINICAL PROBLEM AND CORRESPONDING DIAGNOSIS. NEXT, THE TREATMENT PLAN SHOULD REFLECT A CLEAR SERIES OF GOALS FOR HELPING THE CLIENT THROUGH THE IDENTIFIED PROBLEM. EACH GOAL SHOULD HAVE SPECIFIC INTERVENTIONS PRESCRIBED THAT REFLECT BEST PRACTICES AND EVIDENCED-BASED TREATMENTS TO HELP GUIDE THE CLIENT ALONG THE PATH TO RECOVERY. FINALLY, THE GOLDEN THREAD INCLUDES PROGRESS NOTES THAT DEMONSTRATE THAT THE SERVICES YOU DELIVER MATCH WHAT WAS PRESCRIBED IN THE TREATMENT PLAN. EACH NOTE SHOULD LEAD INTO THE NEXT, CREATING A COMPREHENSIVE STORY OF THE CLIENT'S PROGRESS THROUGH TREATMENT.

• THE GOLDEN THREAD IS NOT ONLY IMPORTANT FOR COMPLIANCE AND REIMBURSEMENT, BUT IT CAN ALSO BE AN IMPORTANT TOOL FOR DELIVERING QUALITY CARE.
ASSUME RESPONSIBILITY OF THE MENTAL HEALTH RECORD

• When you are new to the client, assume responsibility for the record.

• Confirm that the client has an Annual assessment.

• Confirm that the client has a valid client plan, with the correct FAC. Prog, service type, Objectives/interventions, and Client Signature.

• Confirm the client record has a Consent to Treat, HIPAA Notification, and ROI.
A medically necessary service is one which attempts to impact a functional impairment brought about by a symptom of a covered diagnosis.
MEDICAL NECESSITY

- A **Covered Primary Diagnosis**.
- A **Functional Impairment**: as a result of a mental disorder: a significant impairment in an area of life functioning or a probability of deterioration in an important area of life functioning, or, for a child, the reasonable probability of not progressing developmentally as individually appropriate.
- The **Expectation that a Mental Health Service** (the Intervention) will significantly diminish the impairment, or prevent significant deterioration in an important area of life functioning, or allow the child to progress as developmentally appropriate.
IMPAIRMENT CRITERIA FOR MEDICAL NECESSITY TO INCLUDE ONE OF THE FOLLOWING:

• A SIGNIFICANT IMPAIRMENT IN AN IMPORTANT AREA OF LIFE FUNCTIONING, OR

• A PROBABILITY OF SIGNIFICANT DETERIORATION IN AN IMPORTANT AREA OF LIFE FUNCTIONING,

• CHILDREN QUALIFY IF THERE IS A PROBABILITY THE CHILD WILL NOT PROGRESS DEVELOPMENTALLY AS INDIVIDUALLY APPROPRIATE.
Impairment Domains
(as a result of Mental Illness)

- Living Situation
- Daily Activities and Functioning
- Family Relations
- Social Relations
- Finances
- Legal and Safety Issues
- Work and/or School
- Health: does client have the ability to obtain and follow-up with a primary care provider
- Cultural Components
FUNCTIONAL IMPAIRMENT EXAMPLE
ADULT
PRIMARY DIAGNOSIS: MAJOR DEPRESSIVE DISORDER

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>SEVERITY</th>
<th>ADDITIONAL INFO</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HOUSING</td>
<td>• MODERATE</td>
<td>• CLIENT RARELY GOES OUT, ROOM IS DIRTY AND UNKEPT TO EXTENT IT THREATENS ABILITY TO KEEP HOUSING</td>
</tr>
<tr>
<td>• FAMILY AND SOCIAL RELATIONS</td>
<td>• MODERATE</td>
<td>• ISOLATES, GETS ANGRY EASILY WITH FAMILY OR ROOMMATES</td>
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</tbody>
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TREATMENT PLANNING

• The Client Plan is created by the clinician in collaboration with client.

• The Client Plan establishes the link between the services being provided and the impairment.

• Facility/Program (fac/prog) and interventions must be on Client Plan prior to planned services for valid billing.
PLAN DEVELOPMENT DEFINITION

- “Plan Development” means a service activity which consists of development of client plans, approval of client plans, and/or monitoring of a beneficiary’s progress.
PLAN DEVELOPMENT

• Involves actual writing of Client Plans, as well as determining what’s going to go on a plan revision or renewal.

• Submitting to supervisor, getting supervisor signature/approval are administrative, not direct service.
CLIENT PLANS

• **Time Sensitive**: Serves as authorization of services - without an active CP, all planned services will be disallowed.

• **Required**: Must be completed and then authorized by supervisor before finalizing.
  - within 60 days of opening for new client
  - prior to expiration date for renewals

• **Recommended**: To complete assessment and CP early (30 days is aim) to allow time for obtaining signatures and authorization; and in order to start planned services.

• Coordinated Care Plans- some teams have one person responsible for gathering info from team and writing plan for all team members.
CLIENT PLAN: COMPONENTS

• GOALS
• STRENGTHS
• OBSTACLES
• OBJECTIVES
• INTERVENTIONS
• CLIENT INVOLVEMENT/SIGNATURE
GOALS:

• Statement of client’s desired outcome of successful treatment
• Reflect broad life goals
• Essential to hold goal when working with client as foundation of recovery
OBSTACLES EXAMPLES
(MUST RELATE TO MENTAL HEALTH GOALS)

• Acts out in classroom and toward peers
• Voices lead to self harm and hospitalizations
• Has frequent arguments with roommates and unable to see role in contributing to situations
• Is consuming large quantities of alcohol on daily basis
OBJECTIVES

• Objectives are action steps to help achieve stated goals
  • Written so that both client and staff know when accomplished
  • Must address a covered diagnosis

• Objectives must be:
  • Specific and measurable or Specific and observable
  • Tied to the Area(s) of Need/Functional Impairments
CLIENT PLAN
OBJECTIVES & INTERVENTIONS

• If it’s not working, change it.

• If objectives are the same as on previous plans and services are not improving the condition(s), consider new objectives and/or rephrase as preventing deterioration.

• Plan Interventions/modalities must include frequency, duration and be clearly described (frequency can be a range)
ADULT CLIENT PLAN OBJECTIVE EXAMPLE

- **Objective Name:** Improve Social Skills and Community Involvement

- **Client Will:** Client will identify at least one additional weekly activity to decrease anxiety and isolation as a result of mental health symptoms including, enterprise resource center, individual therapy, DBT group, and social activities. Will decrease the frequency of yelling at housemates from 3x daily to 1 by utilizing anger management strategies such as deep breathing, counting, etc. Client will report back on weekly activities and document mood/symptoms on daily symptom sheet.
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CLIENT PLAN INTERVENTIONS

• Intervention section functions as authorization of correct “fac-prog” in CG (Program client is receiving services from)
• Include the Frequency (how often) and Duration (for how long) of each service
• States how the Intervention will help the client’s individualized need
• All services billable to Medi-Cal provided as Interventions must be on the plan
CLIENT PLAN INTERVENTIONS CONT.

• Interventions are linked to the Objective(s) created with client. They are the actual services that the staff person/program will provide to address each Objective on the plan.

• In the Narrative for each Intervention document the details of the service(s) the staff will provide and how each service will assist the client with a particular area of need and identified objective.

• Don’t forget to address case management needs and link to a covered diagnosis
ADULT CLIENT PLAN INTERVENTION EXAMPLE:
BROKERAGE/REHAB

**Intervention Description: Brokerage**

- Staff will provide education on the benefits of voice management group and encourage client to attend, during each meeting. Staff will meet with client at least 3X month to develop strategies and reinforce safety plan.

**Intervention Description: Rehabilitation**

- Staff will engage in developing, role playing, and reviewing strategies from group, 2x a month, to decrease anxiety.
CLIENT SIGNATURES ON PLAN

- Signature is evidence of participation by client
  - Use Client Signature Addendum if program doesn't have electronic signature pads
- DHCS allows statement of acceptable reason why signature not obtained to be documented on Client Plan (on CG)
- Document further attempts to obtain signature on progress notes
- Missing client signatures responsible for many services that can’t be claimed = No Revenue
- During Covid 19, document client involvement and agreement with plan via telehealth (phone or video) and state no client signature due to Covid 19. Must document that client participated and agrees with the client plan.
- Client plan is valid and authorization starts once it is finalized in CG.
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TITLE 9 CALIFORNIA CODE OF REGULATIONS DEFINES ALL SERVICES BHDRS PROVIDES

- Codes that can be used PRIOR to completion of Client Plan:
  - Assessment
  - Plan Development
  - Brokerage (aka Targeted Case Management- (TCM) & Intensive Care Coordination (ICC)- for assessment plan development, and referral/linkage to help a beneficiary obtain needed services including medical, alcohol and drug treatment, social, and educational services.
  - Crisis Intervention
  - Medication Support when urgent
  - Provision of any of service must meet medical necessity

- Codes that can only be used AFTER authorized on CP and CP has been finalized
  - Components of TCM and ICC: (aka Brokerage)
    - Individual/Group Rehab
    - Collateral
    - Individual/Group Therapy
    - Family Therapy (Child Team only)
    - Medication Support (non-emergency)
DHCS ONGOING CARE NOTE REQUIREMENTS

• What “relevant aspects” should be documented?
  • Interventions provided
  • Client response to interventions
  • Clinical decision making, including alternative approaches for future interventions
  • Referrals to community resources/agencies
  • Discharge summary outlining follow-up care
2. What components of medical necessity need to be established and documented in every progress note for each outpatient service?

Components of medical necessity that must be documented in the progress note include the specific intervention that was provided, how the intervention provided reduced the impairment(s), restored functioning, allowed developmental progress as appropriate, or prevented significant deterioration in an important area of life functioning outlined in the client plan, and the beneficiary's response to the intervention.

While not all components of medical necessity must be documented in a progress note, the progress notes must clearly link the intervention to the identified functional impairment(s), which are as a result of the beneficiary's identified mental health diagnosis.

The interventions should be described in such a way that a reviewer reading the note would be able to determine whether the interventions were clinically appropriate to the impairments and whether there was a reasonable likelihood that the interventions would reduce those impairments, restore functioning, prevent deterioration, or allow developmental progress as appropriate.
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DHCS ONGOING CARE NOTE REQUIREMENTS

- Date of service
- Location of service
- Amount of time to provide service:
  - **Time** Includes:
    - **Time to review** the medical record, if necessary
    - **Travel time** needed to provide the service
    - **Duration** of the service
    - **Documentation** time
- Electronic signature, degree, licensure and/or job title
ONGOING CARE NOTES

• Be objective and behavior-focused
• Ongoing Care Notes relate to objectives on the Client Plan

• Hint: It is helpful to remember to be explicit and include:
  • Provided at: (place of service)
  • Provided to: (client, family, etc.)
  • Contact type: (in person, phone, etc.)
  • Purpose of service: (Individual therapy, to practice communication skills, etc.)
CHART NOTE REMINDERS

• Standard: notes to be written within three business days after contact. After three Business days, “late Note” needs to be added to the note.

• All new staff notes are co-signed for first three months

• Time documented for service includes: actual service provided, documentation and reasonable travel time

• Reflect mental health & functional impairment as basis for providing service

• Written in SIRP format
"Brokerage" (Case Management/ Brokerage, TCM) means services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress, and placement services.
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CHARTING TIPS FOR CASE MANAGEMENT

- Tie service into the identified symptoms on the treatment plan
- Use a verb that describes the case management activity (see below)
- Comment on the individual’s functioning in one of the following spheres:
  - living arrangement, social support, health, daily activities
- Document plan for future services and explain how information from the case management session will impact future plans for the individual’s care

CASE MANAGEMENT IS NOT:

- Skill Development
- Assistance In Daily Living
- Training a Beneficiary to Access Services

CASE MANAGEMENT—KEY PHRASES:

- Linked
- Assisted To..., For..., With...
- Monitored...
- Brokered For..., In Regards To..., Concerning...
- Advocated For..., In Regards To..., On Behalf Of...
“Collateral” means a service activity to a significant support person in a beneficiary’s life with the intent of improving or maintaining the mental health status of the beneficiary. The beneficiary may or may not be present for this service activity.
CHARTING TIPS FOR COLLATERAL SERVICES

- Tie the service into the identified behaviors or symptoms noted on the individual’s treatment plan. Do not focus on the significant support person’s behavioral issues.
- Describe how the interventions help a significant support person improve, maintain, or better understand the mental health status of the person served (i.e., putting together a behavioral chart with a parent, teaching how to better reinforce appropriate behaviors, discussing the mental health disorder with the care provider).
- Explain how the interventions are designed to help the significant support person assist the person served with learned interventions.
- Document the significant support person’s response to the intervention(s).
- Document the plan for future services.
- Document the plan for continued services.
REHABILITATION DEFINITION

• “Rehabilitation” means a service activity which includes assistance in improving, maintaining, or restoring a beneficiary’s or group of beneficiaries’ functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education.
  • Intervention must be explicit!
The goal of all mental health services, including Rehabilitation, is to improve the beneficiary’s quality of life and functioning in the community.

REHABILITATION SERVICES—KEY PHRASES:

- Offered Assistance With..., To..., For..., On Behalf Of...
- Offered Training To Consumer In Regards To...
- Counseled Consumer In Regards To...
- Offered Support For..., In Regards To...
- Offered Encouragement To..., For..., In Regards To...
DIFFERENTIATING PROCEDURES

**REHABILITATION**
- Help develop, maintain, or restore skills.

**BROKERAGE (TCM)**
- Coordinate, link, and refer. Monitor progress related to linked services.
WHEN PROVIDING MULTIPLE SERVICES (INTERVENTIONS) IN A SESSION OR MEETING

• Sometimes the intervention provided is not one or the other, but is actually multiple services.

• For example, meeting with a disorganized client to help to maintain housing, reducing clutter, improving hygiene, getting adequate food, seeing his psychiatrist, dealing with money issues, avoiding hassles with neighbors.

• Could contain multiple instances of both brokerage and rehab.
COMPARE & CONTRAST
MIXED INTERVENTION

• Preponderance Rule
  • What took the most time during session
  • What is being written about the most
  • Which seems most important or beneficial to client

• Strategy: read then choose
  • Instead of choosing a procedure and trying to document to fit, write what happened, read it, and choose the procedure that fits best.

• Write separate notes
SIRP CHARTING

This format is required for all notes
(S) Situation
(I) Intervention
(R) Response
(P) Plan
SIRP — SITUATION (S)

• Include a statement of purpose of session, meeting, or service to be provided.

• Clearly describe client’s current complaint(s), and presentation.

• Use behavioral terms; may include a brief statement or assessment of mental status of the client at time of meeting.

• may include a status update of impairment and/or diagnosis
  • don’t cut and paste diagnosis, behaviors and history
INTERVENTION (I)

- Intervention is what you did during the interaction with or for the client to address the situation.
- Intervention is not a description of what’s going on with the client.
- Reminder that reimbursement is for staff time, not client behavior.
- Intervention should be explicit, not just implied.
- Include assessment of risk factors when appropriate.
- Document skills provided to client/family.
SIRP - INTERVENTION

• Use Verbs!
  • Identified skills used to cope/adapt/respond/problem solve.
  • Reinforced new/more functional behaviors, strengths.
  • Pointed out problem behaviors/patterns that could be problematic.
  • Identified/modeled/practiced specific skills that decrease functional impairments.
  • Role played situation in a coffee shop, with landlord, etc.
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INTERVENTION ACTION PHRASES

Assessed mental status
Acknowledged
Clarified Values
Commended clients report of
Conferred with
Explored triggers for anxiety
Facilitated access to
Modeled skills/behaviors
Offered feedback
Practiced role play
Problem solved
Reality Tested

Reassured; Recognized; Recommended
Redirected client to
Reviewed (name) strategies for managing symptoms/situation, etc.
Supported client to
Taught and practiced coping skills
Taught and reviewed relaxation training skills- name skills
Worked together to develop goals and objectives
RESPONSE (R)

• Is documentation of the client’s response to your intervention
• Can be both verbal or non-verbal responses from client

• Examples:
  • Client responded positively to learning coping strategies and agreed to practice on her own
  • Client stated she would contact Primary Care doctor directly
  • Client reported 3 positive interactions with classmates and explained situations that had occurred and what she did to create different encounter.
WHAT ABOUT WHEN CLIENT ISN’T PRESENT?

In instances where there is no direct contact with client or agency, and the service is brokerage/targeted case management the note can be written using SIP instead of SIRP

It is useful to indicate “client wasn’t present”
PLAN (P)

“P” relates to follow up and is reflective of client’s objectives on the Client Plan

• Indicate what next steps will be.
• Specifies action or steps to be taken as a result of the service or contact provided
• Action can be by clinician or client
• Document recommended actions for follow up by client/family
Examples of “P”

• Contacts to be made on behalf of the client (Brokerage)
• Skills the client will be practicing on own or action they will be taking (Rehab or Therapy)
• When the next service or contact will be and purpose of that service or contact
REHABILITATION EXAMPLE

• S: Clinician met with client in the community for a one-on-one session to improve client’s relaxation skills. Client continues to exhibit impaired judgment, low frustration tolerance, and highly reactive when faced with frustrating situations. Appeared somewhat subdued, although anxious.

• I: In order to help client decrease angry outbursts, clinician encouraged the client to utilize coping skills such as deep breathing relaxation exercises and taking quick time-outs instead of reacting to situations. Practiced coping skills to manage anger, clinician and client role-played a recent situation where client reacted to the situation in angry manner. Clinician and client practiced different responses the client could have had. Client was encouraged to use relaxation exercises at least 2x during the following week.

• R: Client reports feelings frustrated when people “don’t understand me….they ask me the same question over and over…..they make me mad.” During role-play, client was able to identify a couple of areas where taking a breath and a quick time-out may have been helpful. Client reported participation in role-play was beneficial and agreed to practice coping skill at least 2 times during the next week, if the situation arises.

• P: Clinician to meet with client in one week and process if the use of the practiced coping skills was helpful or not helpful during stressful situations.
BROKERAGE (TCM) EXAMPLE

• **S:** Client with history of impulsivity and mood swings, which have resulted in situational and legal problems. Client has received 30-day notice to vacate due to non-compliance with rules.

• **I:** Case Manager evaluated housing options due to client receiving a notice to vacate current residence. Explored housing alternatives, including local shelters. Case Manager contacted staff at facilities to assess vacancies and determine whether facilities would accept client or if client would be a good fit. Advocated on client's behalf. Scheduled visits to two facilities.

• **R:** Case manager unable to identify social support system for temporary housing, although was able to find possible openings at other board and care settings.

• **P:** Case Manager will follow-up by contacting other board and care settings. Will continue to inquire regarding availability and advocate on client’s behalf, in order to assist client with finding new place to live. Case Manager will inform client for the board and care interview and will provide assistance and support to client during interview.
ACTIVITIES THAT CAN NOT BE CLAIMED
USE OTHER NON-BILLABLE CHART NOTE

• Transportation
• Activities that are clerical, paying bills, money management services (i.e. cashing checks, bringing money, buying clothes for client, etc)
• Leaving messages
• Calling to schedule appointment with client
• No show by client- Use No Show Procedure code
• Client cancellation – Use cancellation Procedure code
LOCKOUTS

• IMD, Jail or Juvenile Hall
  • No claimable service allowed - Can use “No MC code” for IMD, use Jail location and regular service code for Jail

• Acute psychiatric inpatient - ex. At MGH Unit A
  • Only Linkage/Brokerage related to placement

• Crisis Residential (Casa Rene)
  • Linkage/Brokerage and Meds ok. No other MH services

• Unless billable per above limitations, use other non-billable chart note Procedure Code

• Acute medical inpatient - ex. At MGH medical floor
  • No lockouts
TAKE AWAY MESSAGES

1. Medical Necessity = Covered Dx + Functional Impairment due to Dx + Intervention that can address functional impairments!

2. Client Plans = contract with client to achieve their goals!

   • **Planned services** have to be on Client Plan before beginning to provide the service

   • **Unplanned services** - by definition can’t be on Client Plan

3. All notes must be **finalized** in CG by author after approval by supervisor
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2020 BHRS CLINICAL DOCUMENTATION MANUAL

• WWW.MARINHHS.ORG/